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BETSY LEHMAN CENTER
for Patient Safety and Medical Error Reduction

Nearly 1 in 4 Massachusetts Residents had Experience with a Medical Error in the Past 5 Years

Betsy Lehman Center Releases Research on Patient Safety in Massachusetts

BOSTON- December 2, 2014- Betsy Lehman Center for Patient Safety and Medical Error Reduction (BLC) released new research from Harvard School of Public Health (HSPH), RAND Corporation, and National Academy for State Health Policy (NASHP) on the state of patient safety at its *Zero Harm: Charting a new course for patient safety in our Commonwealth* event in Boston. HSPH's research shows nearly one quarter (23%) of Massachusetts residents surveyed reported that they or a person close to them experienced medical error in the past five years, and of those involved in a medical error situation, 59% said the error resulted in serious health consequences. The most common type of medical error identified was misdiagnosis, which was reported by 51% of affected respondents.

"These results suggest that if the Massachusetts public were more aware of the extent of these real life problems, there would be even more citizen calls for action here," said Robert Blendon, Professor of Health Policy and Political Analysis at Harvard School of Public Health and co-director of the poll.

HSPH conducted the public opinion poll of 1,224 Massachusetts adults in September, 2014. The independent report, ***The Public's Views on Medical Error in Massachusetts***, was commissioned by BLC in collaboration with the Health Policy Commission.

"When Massachusetts consumers receive care in a hospital or doctor's office, fill a prescription in a pharmacy, or reside in a nursing home, we should be assured that we will not be harmed," said Barbara Fain, Executive Director of Betsy Lehman Center for Patient Safety and Medical Error Reduction. "Concerted efforts have been made for two decades to improve patient safety; however, our research indicates medical harm persists across all care settings in Massachusetts and there is urgent work to be done to improve patient safety."

RAND Corporation, led by Dr. Eric Schneider, Director of RAND's Boston office, interviewed more than 40 Massachusetts expert observers of patient safety efforts, including health care industry representatives, clinicians, policymakers and consumers, for their report, ***Patient Safety in the Commonwealth of Massachusetts***. RAND researchers found that awareness of patient safety within the medical community has increased over the past 20 years, but the goal of achieving safer care for everyone has been elusive. Approaches that can reduce the risk of harm to patients in hospitals have not been widely adapted and have not been pursued equally in doctors' offices, community health centers, long-term care facilities, ambulatory surgical centers, and other settings like home care. Leadership is not yet taking a fully proactive role in setting patient safety as a top priority. Cost containment pressures have also distracted many providers from pursuing "zero harm" goals. Expert observers said that information about safety - as it is currently collected and disseminated - is of limited use to consumers making decisions about where to seek care.

“The value of transparency and public reporting of medical errors and their negative effects on patients remains controversial in Massachusetts,” said Eric Schneider, RAND Corporation. “Health care facilities report some types of serious problems like medication errors, infections, and falls to regulators, but views are mixed about the usefulness of the data for making care safer.”

NASHP’s Senior Program Director Jill Rosenthal, MPH, surveyed state officials in all 50 states and the District of Columbia about how adverse medical events are reported in those states. In the report, **Adverse Event Reporting in Massachusetts and Other States: Status and Trends in 2014**, researchers found that Massachusetts is among the 26 states and the District of Columbia that have reporting systems to monitor occurrence of some categories of adverse medical events, a number that has not changed since NASHP’s **2007** survey on the same topic. Research showed Massachusetts is the only state in the nation to require many of its health care facilities to report adverse events to two distinct state regulatory authorities: the Department of Public Health’s Bureau of Healthcare Safety and Quality and the Board of Registration in Medicine.

“Now that we have a deeper understanding of the current state of patient safety in Massachusetts, Betsy Lehman Center looks forward to working with all stakeholders to make meaningful progress on the most critical challenges delaying medical harm reduction,” said Fain.

All three independent studies were commissioned by BLC. The *Zero Harm* event, held at the JFK Presidential Library and Museum, commemorated the 20th anniversary of Betsy Lehman’s death. Betsy Lehman was a prominent *Boston Globe* health reporter who died on December 3, 1994 from a tragic and preventable medical error—an overdose of a chemotherapy drug. In the years since Betsy’s death, improved patient safety measures have been implemented, but preventable medical error remains a critical issue in Massachusetts. Medical errors are the third-leading cause of death in the country, behind only heart disease and cancer with up to **440,000** deaths each year associated with preventable adverse events in American hospitals.

Betsy Lehman Center, reestablished by Chapter 224 of the Acts of 2012, reopened its doors in December 2013 under G.L. c. 12C, § 15 as an independent state agency supported by the Center for Health Information and Analysis (CHIA). It has a broad mandate to advance patient safety in Massachusetts through research, dissemination, and provider and public engagement. Originally launched in 2004, the Center operated within the Massachusetts Department of Public Health until 2010.

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